PRINTED: 09/30/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 505512 B. WING 09/26/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **491 SOUTH 338TH STREET** GARDEN TERRACE ALZHEIMER'S CENTER OF EXCELLENCE FEDERAL WAY, WA 98003 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) **INITIAL COMMENTS** F 000 This report is the result of an unannounced Abbreviated Survey conducted at Garden Terrace Alzheimer's Center of Excellence on 0/26/2013, A sample of four residents were selected from a census of 53 and included the closed records of 1 discharged residents. This survey included investigation of the following complaints: #2869891 RIFICIEIVEID

OSHSIADSAIRCS Region A

DSHSIADSAIRCS Region A Survey team members included: MSN. RN., Complaint Investigator The survey team is from: Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities District 2. Unit F 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388

Telephone: (253) 234-6000

Fax: (253) 395-5070

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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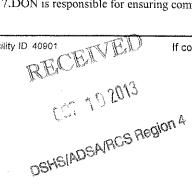
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		505512	B. WING			09/26/2013		
NAME OF PROVIDER OR SUPPLIER GARDEN TERRACE ALZHEIMER'S CENTER OF EXCELLENCE				STREET ADDRESS, CITY, STATE, ZIP CODE 491 SOUTH 338TH STREET FEDERAL WAY, WA 98003				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff transcribed a physician's order for anti-hypertensive medication correctly. This failure placed one of four residents (#1), reviewed for physician order transcription, at risk for complications associated with low blood pressure. Findings include:			309	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. F 309			
					1.Resident #1 no longer resides at the far Resident #1's medication regimen was and reconciled to ensure accurate transand correct dosage. Resident was assess monitored for response to medications. 2.All other residents' medications were reconciled for potential discrepancies as ensure medication administration reconaccordance with physician orders. Staff trained on steps for processing phorders.	reviewed cription sed and ed and e nd to ds are in		
	According to the 08/28/2013 Minimum Data Set, year old Resident #1, was cognitively impaired, easily distracted, experienced disorganized thinking and required extensive assistance of two staff for activities of daily living including bed mobility, transfers and toileting. Resident #1 was observed, on 09/26/13 at 2:50 p.m., sitting in a wheelchair with other residents watching a movie. A pink cast was observed on the left arm. When interviewed the resident was unable to explain how she suffered a fracture. Review of the facility's 08/28/13 and 08/30/13, evidence of investigations revealed Resident #1 experienced a fall on 08/28/13 that resulted in				3. Facility established a system that incl having two licensed staff verify admission medication orders to decrease likelihood transcription errors. 4. The facility will monitor performance completing weekly audits x 4 and then Audit results and information related to medication errors will be reviewed most the Quality Assurance meeting. 6. The date of compliance is 10/17/13. 7. DON is responsible for ensuring complete the properties of the compliance of the complete the complete that the complete the complete that the complete the complete that the complete t	sion ed of by monthly. nthly in		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 04QG11

Facility ID 40901

If continuation sheet Page 2 of 3



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505512			B WING		[09/26/2013	
	PROVIDER OR SUPPLIE	R IMER'S CENTER OF EXCELLENCE	STREET ADDRESS, CITY, STATE, ZIP CODE				
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F 309	fractures to the leftinger. According assessed the respressure of 138/6 118/70. The fifth Nursing, defined decline in systolic millimeters of methypotension." Subsequent to the Resident #1's mediscovered the operator of the operator of the operator of the page 1276, a side "Marked orthostal loss of conscious Interviewed on Control Director of Nursion D) who transcromputer had eadministration from a result of the transcrived two domedication.	eft wrist, and the right middle of to this document staff sident to have a lying blood 50 and sitting blood pressure of edition of Gerontological orthostatic hypotension as, "A coblood pressure of 20 ercury or moreis postural effect of the facility reviewed edication regimen and riginal physician's order for digrams every evening was the Medication Administration (twice daily). According to the see Geriatric Dosage Handbook de effect of this medication was, atic hypotension, syncope and sness" 19/26/13 at 02:30 p.m., the sing indicated, one of two Staff (Corribed physician orders into the roneously increased the some once a day to twice a day. As anscription error Resident #1 ses of the antihypertensive for nine days, 08/21/13 3. Resident #1 experienced the	F 309	RT	CENVEID 2013 2013 HSIADSAIRCS Region		